

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157638	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 06/10/2015
NAME OF PROVIDER OR SUPPLIER FOSTER HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 445 GRADLE DRIVE CARMEL, IN 46032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{G 000}	<p>INITIAL COMMENTS</p> <p>This was a re-visit for the Federal complaint survey completed on 3-17-2015 that resulted in an extended survey.</p> <p>Survey Dates: 6-9 and 6-10-2015</p> <p>Complaint #: IN00160254; Substantiated - Federal deficiencies related to the allegation were cited. Unrelated deficiencies were cited.</p> <p>Facility #: 012508</p> <p>Medicaid Vendor #: 201050820</p> <p>Current Census: 17 Skilled 26 Home Health Aide only 43 Total</p> <p>Six (6) Conditions of Participation and twenty-one (21) standard level deficiencies were found corrected during this survey.</p> <p>Foster Healthcare was found to be in compliance with the Conditions of Participation 42 CFR 484.</p> <p>Foster Healthcare is precluded from providing a home health aide training and competency evaluation program for a period of 2 years beginning 3-17-2015 for being found out of compliance with the Conditions of Participation 42 CFR 484.14 Organization, Services, and Administration; 484. 18 Acceptance of Patients, Plan of Care, Medical Supervision; 484.30 Nursing Services; 484.36 Health Aide Services; 484.48 Clinical Records; and 484.55</p>	{G 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{G 000}	Continued From page 1 Comprehensive Assessment of Patients. QR:JE 6/12/15	{G 000}			